TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Steve Sacks MD

Respondent Name
Liberty Mutual Insurance

MFDR Tracking Number
M4-15-3788-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This request was in response to a $314.08 reduction of the $929.87 for the EMG performed on 1-28-15. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $314.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Two units CPT Code 95886 were denied as documentation does not support this level of service. This code requires a study of five or more muscles, innervated by three or more nerves, per extremity. Based on the EMG/NCV report received, only 4 muscles per extremity were studied. HCPCS Code A4556, electrodes per pair, is not separately payable per Medicare guidelines as it is considered a bundled/non-covered procedure."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2015	95886, A4556	$314.08	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment

codes:

- X901 – Documentation does not support level of service billed
- W3 – Additional payment made on appeal/reconsideration
- U630 – Procedure code not separately payable under Medicare and or fee schedule guidelines
- 193 – Original payment decision is being maintained

Findings

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed service 95886 units of service (2) with claim adjustment reason code X901 – "Documentation does not support level of service billed." 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;"

   Review of the submitted documentation finds;

   a. The description of 95886 is – "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels.

   b. EMG Study: L. Dors. Int.l (no results), L. Abd.Pol.Br, R.Abd.Pol. Br; L.Dors.Int.l, R.Dors.Int.l; L.Flx.Car.Rad, R.Flx.Car.Rad; L.Ext.Car.R.Ln, R.Ext.Car.R.Ln.

   A total of four muscles were tested on both the left and right side. The code submitted indicates five or more muscles tested. The EMG report does not support five or more muscles were tested times two units. Therefore, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. 28 Texas Administrative Code § 134.203(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;" Procedure code A4556, service date January 28, 2015, has a status code of P – "Bundled / Excluded Code." No additional payment can be recommended.
3. The total allowable reimbursement for the services in dispute is $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.